

**REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATIONAL CLEARANCE FOR TRAVEL***(This Form is Subject to the Privacy Act of 1974 - USE BLANKET PAS - DD FORM 2005)***SECTION I - SPONSOR'S DATA**

A. NAME (Last, First, Middle Initial)		B. GRADE	C. SSN	D. DUTY / HOME PHONE
E. PRESENT LOCATION	F. LOSING MPF LOCATION	G. LOCATION OF FAMILY MEMBERS' MEDICAL RECORDS <input type="checkbox"/> Military Facility: <input type="checkbox"/> Civilian/Network Provider:		
I. MO/YR OF TRAVEL (If applicable)	J. PROJECTED UNIT/LOCATION	K. GAINING MAJCOM	L. PROJECTED AFSC	M. Q CODE <input type="checkbox"/> YES <input type="checkbox"/> NO

**SECTION II - FAMILY MEMBER DATA****INSTRUCTIONS**

ALL sponsors with school-age children and those enrolled in Early Intervention must complete DD Form 2792, Addendum B, *Special Education/Early Intervention Summary*.

EACH family member with an exceptional medical need must have a completed DD Form 2792, *Exceptional Family Member Medical and Educational Summary*.

Medical/Emotional/Behavioral - Conditions requiring services outside primary care.

Dental - Care beyond routine annual dental exam or cleaning.

Educational - Any child with an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

IDEA Services - IEP/IFSP requiring Occupational Therapy, Physical Therapy, Speech Therapy, Psychological and/or Audiology services

Modified Housing - Special housing requirements for documented exceptional needs.

**A. FAMILY MEMBERS ACCOMPANYING SPONSOR****CHECK ALL CONDITIONS THAT APPLY**

FAMILY MEMBER'S NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	GRADE IN SCHOOL	MEDICAL / EMOTIONAL / BEHAVIORAL	DENTAL	EDUCATIONAL	IDEA SERVICES	MODIFIED HOUSING	NONE

**B. FAMILY MEMBERS NOT ACCOMPANYING SPONSOR**

FAMILY MEMBER'S NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	GRADE IN SCHOOL	MEDICAL / EMOTIONAL / BEHAVIORAL	DENTAL	EDUCATIONAL	IDEA SERVICES	MODIFIED HOUSING	NONE

**SECTION III - STATE DEPARTMENT DUTY**

IS THE MEMBER BEING ASSIGNED TO STATE DEPARTMENT DUTIES? ☐ YES ☐ NO

Members assigned to State Department duties: The Family Member's Medical and Education Clearance will remain valid through departure for duty station (departure may be delayed for several months based on training requirements). This clearance will only be subject to a medical administrative review of records after training is completed and prior to departure for station to ensure that no significant change has occurred. All significant changes will be referred to HQ AFMOA/SGZC, Bolling AFB, DC 20332-5113.

**SECTION IV - CERTIFICATION OF APPLICANT**

I understand that I must inform the Special Needs Coordinator (SNC) of any changes in Section II above.

I understand that insufficient and/or inaccurate information may affect family member travel.

I certify that I have read and understand the above instructions and that those entries made by me are true, complete and correct to the best of my knowledge and belief. I understand that a knowing and willful false statement can be punishable by a fine and/or imprisonment (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

DATE	NAME & GRADE OF MEMBER	SIGNATURE
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SPONSOR NAME (Last, First, MI):		SSN:		
<b>SECTION V - MEDICAL PROVIDER ENDORSEMENT</b>				
<b>INQUIRY</b>			YES	NO
A. All Family Members' Medical Records Reviewed? <i>(If NO, see comments)</i> _____				
B. All Family Members' in Section II.A Interviewed? <i>(If NO, see comments)</i> _____				
C. Special Medical Conditions Identified? <i>(If YES, complete DD Form 2792)</i> _____				
D. DENTAL				
Have all family members age 2 and older had a dental examination within the last 12 months? <i>(If NO, complete Dental Addendum)</i> _____				
Do any family members have unresolved dental care needs/problems, such as untreated dental cavities, toothaches, orthodontics, periodontal conditions, TMJ/TMD, etc. <i>(If YES, complete Dental Addendum - AF Form 1466DH)</i> _____				
COMMENTS:				
DATE	NAME & GRADE OF MEDICAL PROVIDER	SIGNATURE		
<b>SECTION VI - SPECIAL NEEDS COORDINATOR ENDORSEMENT</b>				
<b>INQUIRY</b>			YES	NO
A. History of Family Advocacy Involvement? <i>(If YES, complete DD Form 2792, Addendum A-2)</i> _____				
B. History of Mental Health Needs? <i>(If YES, complete DD Form 2792, Addendum A-2)</i> _____				
C. Requires Modified Housing <i>(If YES, see comments)</i> _____				
COMMENTS:				
D. Special Needs Identified Requiring Facility Determination Inquiry			NO - Travel Recommended; Forward to MPF	
			YES - See Section VII	
DATE	NAME & GRADE OF SNC	SIGNATURE		
<b>SECTION VII - FACILITY DETERMINATION INQUIRY DISPOSITION BY GAINING MTF</b>				
Family Member Travel is:			Recommended	
			Not Recommended for Family Members as Indicated Below	
COMMENTS:				
DATE	NAME & GRADE OF SGH AT GAINING MTF	SIGNATURE		